David A. Detrisac, M.D.
Erich E. Hornbach, M.D.
Brian R. McCardel, M.D.
Michael P. McDermott, M.D.

Kenneth M. Morrison, M.D.
Gregory M. Uitvlugt, M.D.
Abbas Zand, M.D.
Bone Density Center

IF THIS IS A WORKERS COMPENSATION OF LIABILITY INJURY, PLEASE GIVE THIS FORM TO YOUR EMPLOYER OR RESPONSIBLE PARTY. IT IS YOUR RESPONSIBILITY TO HAVE THIS FORM COMPLETED BY SOMEONE WITH AUTHORITY AND RETURN IT TO OUR OFFICE. IF NO AUTHORIZATION IS GIVEN, YOU WILL BE REPSONSIBLE FOR PAYMENT OF SERVICES RENDERED.

DATE: ________________________

________________________________ is/was here to see Dr. ______________________________
(Patient's Name)

on ________________________, concerning an injury on ____________________ to his/her
(Appointment) (Date of Injury)

____.
(Area to be examined)

The patient states that this is a work related or liability injury.

By signing this form below and returning it to our office, you will be authorizing our office to bill you for his/her treatment.

__________________________________ __________________________________
Insurance Carrier Policy/Claim number

__________________________________ __________________________________
Address Effective Date

__________________________________ __________________________________
City/State Zip Code Phone Number

__________________________________ __________________________________
AUTHORIZED SIGNATURE Patient's Signature

If the employer or responsible party feels they are not liable for payment of the above claim, please notify our billing department.

Thank you.

3394 E. Jolly Road, Suite A. Lansing, MI 48910 ◆ Phone: (517) 394-3200 ◆ Fax: (517) 394-4250